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ABSTRACT

Current mental health services for Indian people living on and off the reservation are described for individuals interested in expanding or delivering mental health services to Indian people or in the state of the art. The conference held in July 1979 was established for the purpose of sharing information about successful mental health programs. The first group of programs described are mental health services which have established themselves in a Native American community by making contacts and proving their services reliable with an explanation of planning and development from a range of highly structured needs assessment of timely and spontaneous use of available resources. The second group of programs offer solutions to challenges by evaluating needs, identifying target populations and performing outreach as major elements of service delivery; using these approaches program staff can contract with tribal groups or other health service providers and provide backup to existing programs. Efforts discussed in the last group of programs are suggestions in dealing with prejudice and racism as one element of preventive mental health work and use of inservice training for staff and cultural activities for the community. Other topics summarized and briefly discussed are professionalism, cultural-racial issues, and conceptual orientation. (ERB)

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PROGRAMS & SERVICES

MENTAL HEALTH for NATIVE AMERICANS

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JULY 23-25, 1979

NORTHCENTRAL MONTANA CMHC

REGION VIII ADAMHA-HEW

CENTER FOR MINORITY GROUP MENTAL HEALTH PROGRAMS NIMH

MENTAL HEALTH FOR NATIVE AMERICANS

PROGRAM DEVELOPMENT AND MANAGEMENT

William J. Taylor, Ph.D.

Editor

January 30, 1980

Northcentral Montana Community Mental Health Center
P.O. Box 3048
Great Falls, Montana 59403

Evan S. Crandall, Director

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INTRODUCTION

The programs described in the following chapters are offered as a bench mark of current mental health services to Indian people living on and off the reservation. If you are interested in expanding or delivering mental health services to Indian people, or if you are interested in the state of the art, this information can be of use to you. If you are problem oriented, or if you are interested in deficiencies of health care systems, this information will be of little value. The conference from which these programs were presented was established for the purpose of sharing information about mental health related programs that were working. The specific objectives of the conference were:

A. To present a number of successful programs currently in operation within the region which targeted identified populations such as children, families, and those with special needs such as the alcoholic.

B. To identify pathways of successful management and interagency cooperation which enhance the delivery of mental health services to Native Americans both on and off the reservation.

C. To develop alternative approaches to common problems of Native Americans which may be readily transferred to suit different tribal, manpower, and economic resources of different mental health centers.

D. To contribute to the establishment of a knowledge base for the management and programming of mental health services to Native Americans.

The management and programming of mental health services for Native Americans is a complex and incompletely understood task area. Diversity among Indian people, interagency and governmental conflicts, as well as the absence of a uniform body of knowledge in the area, are among factors limiting growth in service delivery. At the present time, only one professional journal directs

itself to issues of Native American mental health (White Cloud Journal) and its first issue was published in the spring of 1978.

In the absence of adequate informational sources, or when a common body of knowledge does not exist, workshop-conferences are proven vehicles for the sharing of experiences and introduction of new or innovative management and programming.

A survey conducted by Dr. Stan Mahoney, Region VIII, NIMH-ADAMHA, in 1978, revealed that ten of the centers offering comprehensive mental health services in the region had a Native American population of 84,609, which constituted 8.1% of their total population. This population consisted of both on and off reservation groups. The survey indicated further that although services, staff and boards had representative proportions of Native American participants, respondents were unifo 'y concerned about the scope and variety of services they offered.

A follow-up telephone survey conducted by the Northcentral Montana Community Mental Health Center, revealed that each center had one or two programs which were exemplary, but areas of need which were unmet or underserved. The survey further indicated that there was a low level of awareness among program managers and service providers for the array of programming within the region. Respondents expressed a desire for information about successful programs and management procedures which would help in doing a more comprehensive program of services to Indian people.

The program descriptions and discussion which follow include demographic information as a standard for comparison. Comments and discussion by participants are summarized at the end of each chapter and a final issue-oriented summary of the conference completes the publication. The style of presentation reflects the differences in orientation, attitude, skill, and experience of the different presenters. As much as possible, this individual style has been

retained to clarify the nature of the program under discussion and the relationship to the people who deliver and use it. The reader can expect anecdotal comments, some hard data, and first person accounts of critical incidents. Our hope for the conference was disclosure, sharing, and program development. Our hope for this publication is the same.

We are particularly appreciative of the efforts of the participants for preparing the materials for presentation and sharing their work with us. We are also grateful for the help of Mr. Richard M. Shapiro, Assistant Chief, Racism and Mental Health of the Center for Minority Group Mental Health, NIMH, and Dr. Stan Mahoney, Region VIII, NIMH-ADAMHA, who provided the technical assistance grants which supported the workshop-conference and this publication. We are also grateful to our colleagues in the Indian Health Services who attended and contributed freely to the success of the conference and who continue to support our work in the field.

William J. Taylor, Ph.D.

Editor

CHAPTER 1

LOCATING LINKAGES AND DEVELOPING MANPOWER

The first step in establishing mental health services in a Native American community is making contacts and proving the services reliable. There is no formula for establishing relationships of mutual trust and respect. Such relationships require patience, spontaneity, and persistence. The program described by Dr. Gerrish is outstanding in that regard. He has been a county head of service, working alone in the office, for over six years. The programs which make up this chapter reflect a range of service approaches which could have broad applicability. All depend upon support from other agencies for the delivery of services and direction in their operation. The planning and development that went into the programs described in this chapter range from a highly structured needs assessment to the timely and spontaneous use of available resources. The programs were chosen for inclusion in this unit because they reflected several solutions to the problem of locating linkages and developing manpower.

Duff Gerrish, Ph.D., Western Montana Community Mental Health Center, Ronan, Montana.

The Western Montana Regional Mental Health Center serves an area of approximately 19,374 square miles. Lake County, in which Ronan is located, contains the Salish-Kootenai Reservation, with a population of 2,500 enrolled tribal members. The County, as a whole, has a population of 18,000 people. It has been variously estimated that there are an additional 500 to 1,000 Indian residents in the County who are not registered members of the tribe. Geographically, the reservation and County are located west of the Continental Divide and with borders on Glacier National Park. The region is considered one

of the most scenic in the State and nation.

My presentation will be based upon personal experience. I really do not know that a well established theoretical position exists which could explain what has been developing in my area. My experience is offered as a starting point for discussion. My work, as head of service in a satellite office of a regional mental health center, actually began before I took over that position. For two summers, I had the opportunity to work as project psychologist for the tribal Headstart program. During that time, I visited each of the Headstart centers at least once a week. This gave me a chance to meet a variety of people on the common ground of working with children. I have a rather informal style that works well for me and that seems to put people at ease. A highly professional approach might suffocate relationships there. Establishing yourself as a credible human being first, and backing it up with professional expertise, is most important.

In working with Native Americans, it is helpful to be aware that we are talking about white Europeans entering a strikingly different culture with a long-term independent existence. We need to be able to understand not only the values of Native Americans, but also how they live. Right now, there are new physicians working on our reservation who have never been to a Pow-wow. How can you understand what Native American values are if you have never seen how they live....or seen their celebrations? At the least, we must try to gain some respect for their way of life. Sitting in an office 40 hours a week is a futile waste of time. The mental health person must get out and know people. If you offer a quality service and you meet and talk to people, you will see they begin to come in for direct service.

When I first began in the office, I was alone. At first I developed a good relationship with the local alcohol program. A lot of time was spent working

with paraprofessional counselors....using those contacts as training sessions. That program was providing many unique services that I could not offer. By complimenting each other, we were able to work very well together. From that base, I reached out to other agencies serving tribal people. The Kicking Horse Job Corps Center was another important facility. That relationship lasted for two and one half years and followed the same format as my work with the alcohol program. Now there has been good progress in staff development and programs to the point that my services are no longer required. Many of the things I worked for in that program have come to fruition. At one point in my consultive work, I became an advocate. I quickly learned that if you are not careful about who you ally yourself with and how you use political relations, you can sacrifice yourself. On reservations, power and power structures are not the same as they are elsewhere. They are based upon kinship lines to a much greater degree.

Racism, for me, seems to be less of an issue the longer I work on the reservation. Generally, when I am accepted, it does not matter who I am. What matters is whether I can do the job, and my acceptance seems to be on that basis. I strive to be there as a human being even though I am an outsider. I have become sensitive to this because I have seen people come to the reservation who say they understand Indians because they have been living in a teepee. In my experience, if Indians live in a teepee, they want to get out of it. People sometimes say they want to follow the Indian way....but there are many years behind that way.

Identity is another important issue whether you work with the Indians on or off the reservation, in a rural or urban setting. I think of it as a question: How can I help the Indian people in a white society without making a white man out of him? What approach will give the individual the option that he can go one way or the other with dignity and respect? Frequently, it seems that our

society is not eager to make it easy for the minority person to move around. We must guard against putting down an individual who is making a choice about his identity. I have discovered that it is possible to build on a person's choice of identity and to provide opportunities to teach educational skills.

Not knowing our own identity, knowing where we are and who we are, will blind us to the identity of others. Indians need the same consideration. I have learned of a factory which uses many Indian people as employees. There never seems to be many people around, yet the work gets done. Some wise individual set up the factory on a piecework basis that reflects the Indians' sense of the appropriateness of time. Workers come and go whenever they want, which is a practice closer to the cultural preferences of the people. This gives them the ability to earn and work, and still preserve some of the values of their culture.

It is in the living through of our credibility as human beings, of our own personal style, and the way we value others who are different, that programs with Indians operate best. Just putting on behaviors, although there is a place for knowing what those behaviors mean, is not enough. It is our own personal acceptance of the needs of different identities that, when put into action, makes program. Building cooperative relationships with a variety of helpers has made it possible to provide services that one individual, no matter how trained or qualified, could never do alone.

Ed Bates, ACSW, Department of Institutions, Manpower Project, Helena, Montana.

The Montana United Indian Association (MUIA) and the Manpower Project of the Department of Institutions have been working together to develop a project which will be targeted to 15,000 to 20,000 off-reservation Indian people. The

project grew out of an awareness that Indians were underrepresented in the mental health statistics despite disclaimers to that. I discovered that there were several reasons for the underrepresentation, not all of which were the centers' responsibility. MUIA is a non-profit group headquartered in the capitol with offices located in eight communities throughout the State. It is probably the only statewide consortium to deal with off-reservation Indian concerns in the nation. The project was based upon a carefully conducted needs assessment carried out through the MUIA program. Three background issues emerged from the assessment:

1) Off-reservation Indians are a special group of people in extraordinary flux with unique cultural and historical problems. They are a very mobile population, moving from a very kept society to a very competitive one and not having the skills to cope. They are economically and psychologically dependent. There is political and organizational disunity. One cannot talk about Indian power in the same sense as black power because Indians are a tribal people. There are many mental health problems in this group, including high rates of suicide and alcoholism.

2) All symptoms of emotional and social breakdown are indicative of related factors; i.e., self-destructive behavior, destructive behavior toward others, and general psychiatric symptomology.

3) Associated causative factors include prejudice, apathy, general depression, isolation, and poor self-image. Poor self-image is one of the outstanding issues for mental health centers to confront.

Barriers to service exist in the mental health system and in the general Indian community as well. Efforts to improve self-image are often stymied by a strong sense of pride. Frequently, Indian people espouse the cultural value of non-interference which leads them to not becoming involved in the lives of other

people. We believe this explains, in part, why Indian people do not reach out to community mental health centers in the numbers their problems would suggest they should.

Another cultural barrier to using mental health services comes from the socialization practices of Indian people and their influence upon the conceptual orientation of the people. A Canadian Cree poet has said that both Indians and whites learn the same language, but they learn it differently. The Indian child is given encouragement to experience first, then he is given the language to describe the experience. Thinking thus becomes concretistic and specific; he does not consider issues symbolically, which he has not actually experienced first. The non-Indian child learns language first, before he is permitted to really experience much. The thinking of non-Indian children becomes more abstract and philosophical as a result. The non-Indian is more primed to engage in talk therapy offered by the community mental health center. This dissimilarity is an issue which has not been fully addressed by professionals in reaching out and providing services to Indian people. Our program is an effort to get at such cultural inequality.

Rural isolation is an additional barrier to service delivery. Every state has its ruralness, but in western states, we are confronted by the social cost of that space. Among minority groups in the United States, 12% of Chicanos are rural, 22% of blacks are rural, but 55% of Native Americans are rural. Mental health planners use the normalization principle in efforts to overcome the lack of resources characteristic of rural Native American settings. This approach is more culture specific and concerns itself with questions of cultural norms. We talk about bringing these people up to something that is normal in their culture. As an example: What is mental health in the Indian culture? What resources does the culture use in confronting this issue? How do they perceive

mental health? How is their religion involved in mental health issues?

The specialized health services and the Indian Health Service in Montana focus on the reservation Indian. There is little involvement with the off reservation Indian. Tribal officials and the Indian Health Service feel that non-reservation Indians can be taken care of by the State and county. Federal money is needed for the tribal people on the reservation. City and county commissioners feel that Indian people are wards of the government and they do not have to be concerned about them. There is no clear delivery system to meet the variety of problems presented by off-reservation Indian people. The multiplicity of educational, legal, health, political and social problems is not taken account of in our current service delivery system. As a consequence, funding is correspondingly fragmented.

From the needs assessment and demographic background, we developed goals and objectives based upon three key concepts: 1) Indians would be the providers of the services. If we were going to come up with a mental health program that would be culturally acceptable to off-reservation Indians, then we were going to utilize Indians who could understand some of these cultural concerns in the provision of services. 2) A focus on the "whole man" concept. Mental health would not be viewed from the narrow perspective of a psychiatric concern, but rather from the wider perspective of employment, family and educational issues; i.e., anything that might put stress on that family. 3) Linkage with the existing local mental health centers. We were not simply going to look for separate monies to duplicate an existing system. Those resources could be used reciprocally; the community mental health centers could learn to work more effectively with the Indian people as well.

The goals of the project were to: 1) establish "cultural specialists" in the alliance offices who would be working with and out of the mental health

centers; 2) establish cooperative agreements with the Montana community mental health centers. These agreements would cover case supervision, mutual consultation and specific provision of care for some of the Indian people; and 3) to continue education services for mental health center staff.

Five specific objectives were developed to operate the program. First is the selection, training and supervision of the "cultural specialist". Next is development of a training program using specifically selected and developed training modules around a skill-oriented focus. Negotiation of specific center agreements has begun; the centers are very interested in the possibilities. To develop a data base that will more accurately assess what the real mental health needs of off-reservation Indians are. Lastly, to provide technical assistance to other agencies, tribes and particularly the mental health centers.

Darlene Bogner, Lewis & Clark Mental Health Center, Yankton, South Dakota.

The Lewis and Clark Community Mental Health Center is located in the southeast corner of South Dakota near the Missouri river. Native Americans consist of approximately 2.5% of the catchment area population. In 1978, the center provided services to 82 Indians which was 6% of the center population served. The center has no specific Indian program, as such. Services are offered as a regular part of the center system. Our efforts have been directed to working with the existing Indian Health care services and acting in consultation with them. Mr. John Johnson, who is our liaison and colleague with the Indian Health Services, will share his experiences about our efforts as well.

Briefly, most areas of the mental health center program serve some Indian clients. In particular, the outpatient services provide alcohol counseling with the Women's Correctional Institution in the State Hospital. The partial care

program serves a number of Indians at the Men's Halfway House. Until recently, the center had a young Indian counselor who was a recovered alcoholic with the program and his work with both the Indians and whites was exceptional. It has been our conclusion that the center needs Indian professionals on the staff. They are able to relate a lot better to their people and they enable the rest of the staff to work better with Indian people.

The center maintains an outreach clinic in Wagner which is located in the reservation area. A center psychologist makes the trip two days a month. While there, he works with the Public Health Service Hospital with John, the social worker for the Indian Health Service. Actually being in the area and working on the community level with professionals, for whom the people have confidence, has been helpful in establishing relations with the tribal people. The outreach office has been successful in developing consultation and education programs which have been of interest to the tribal people. Particularly good responses were obtained for a program dealing with alcohol, drugs and spouse abuse.

The only mental hospital in South Dakota is in our region. Consequently, many people, both Indian and white, stay in the area after discharge. Many times we are able to make contact with the Indian patients during their hospitalization through an association that has been established with a young Indian woman who is a counselor in the drug unit. When an initial contact starts there, it is much easier to follow through and offer services afterward.

Through consultation and education, the center has provided services to the Indian school. Center professionals work with the children and staff of the school. This work has enabled us to develop more lasting services to Indians in the younger age groups.

Much of our work with the Indian people in our area has been because of people like John Johnson and the other agencies who serve the Native American.

Some of the problems of prejudice, suspicion and distrust, which come from both sides of the community, can be overcome through the help of established workers. The key element is having Indian people on the professional staff. Working with Indian people who are in positions, such as a counselor, can assist center staff when working with a client who does not trust the staff. This year, our center will be adding an Indian woman with an Ed.D. who wants to learn about mental health centers in order to establish a center on a reservation. Through such staff and programs, our center is building a Native American program in response to the needs of the community.

John Johnson, Social Worker, Indian Health Service, Wagner, South Dakota.

This presentation will focus on what can be done to bridge the gap between the mental health center and the reservation, as we have worked in our region. I believe that mental health centers have a lot to offer on reservations to tribal people. On our reservation, 20% of the population is Indian and the remaining 80% is white.

Basically, we confronted issues in the development of services: 1) A systems barrier in which two service systems clash, and 2) cultural barriers. My presentation is not directed toward the second issue, although I believe it is a formidable one. The previous presenters have spoken of cultural barriers, and it will be addressed in greater detail throughout the program.

A consultation and education approach was the first step taken to break down the systems barrier. The Center Director, Dr. Engen, and other staff members were invited to the reservation to make single presentations on specific topics three or four times during the year at the tribal headquarters. We met at other places as well where Indian people could become involved. Tribal people helped select the topic in advance, which they wanted the center to deal

with. As a way of interesting people on the tribal council, the programs were sometimes held at the headquarters. The center, in its monthly information sheet Concepts, published an article by Dr. Townsley, an Indian psychiatrist. After the article had been circulated, Dr. Townsley was invited by the Center to come to the reservation and Yankton, to appear at tribal headquarters and meet the center staff.

Greater acceptance and service visibility was gained when the center hired an Indian nurse. This was an essential step in signaling our intent. Having Indian staff involved makes the services much more acceptable to the Indian people. Native American staff do not have to deliver all the services, but they have to be there, working side by side on the team. Combined with the visiting specialists and the educational activities, good groundwork was laid for the establishment of an outreach clinic. The clinic began with Dr. Engen coming on a once monthly basis and has now increased to twice monthly.

Another system barrier which needs to be confronted is the issue of "turf". Sometimes, mental health centers say, "We are the mental health delivery people....we are trained, we are the specialists." Sometimes, the Indian Health Services people say, "These are my people." So the systems knock heads. At other times, the Department of Public Welfare staff may be in opposition to the various health care givers. We believe that no one is helped in this way, and the people who are hurt by it are the clients and the care givers themselves. Our programs have arrived at the point where they are not in competition. We make services available, then let the people choose which system they want. Choice is an important part of satisfaction. People often feel they get better service when they can choose. Our systems are not in competition, we are really in collaboration for the people.

Another issue our systems battle is the underlying belief that mental

health centers are to serve the taxpayers of the area. Since this is not a socially desirable attitude, it is not stated directly; yet, in my experience, it is there. It is said that Indians are not so much taxpayers, but tax recipients, so agencies might not work as hard to deliver services to Indians because they are not paying customers. In correcting this idea, we must see that money is given for services to clients, and regardless of where the money originates, it should be used to deliver services to the people. Such awareness will correct the belief that the Indian Health Service should be the only one that cares for Indians and the mental health center is the one who should care for the other taxpayers.

In my experience, Indian Health Service feels collaboration is of extreme importance - face to face - not just over the telephone. I go into the center and they go out to the reservation. Because of the proportions of non-Indians on the reservation (80%), whatever effects one client group is going to effect the other as well. When the outreach clinic started, it was one-half day at the Indian Health Service and one-half day at the community hospital, but to reduce what appeared to be polarization, arrangements were made to allow non-Indians to come to the Indian Health facility and Indian people to come to the community hospital....whatever was the best for their schedule. This arrangement permitted greater choice of scheduling and treatment setting as well as a chance for the groups to mix.

The solutions for the issue of systems barriers have come from patient focused open dialogue in face to face contacts. Fortunately, money has not become the main issue. It is embarrassing, as a referring professional from one agency, to not be able to pay for clients. Lewis and Clark Mental Health Center has said that money is not the main concern. They will get the service to the Indian people. On the other hand, Indian Health Service has been able to do

things for the center to show their appreciation for what has been accomplished.

A helpful component of this concern for one another is that we have not been held to a medical or mental health model which implies that, "I'm the therapist and you are the patient. You will come to me and I, by my superior knowledge and skills, will help you." This idea is played down. To attempt to build such an orientation into service delivery for the reservation would be to defeat service. As Mr. Bates mentioned before, you have to get out and do teaching, consulting and a lot of mental health education. You have to get away from the therapist-patient point of view. Indian people are not impressed by degrees as much as they are by human warmth, the feeling that people care, and tangible evidence of it. Traditionally, in the mental health field, people come to the therapist. On the reservation, the therapist may have to make himself available to the patient, he may have to go out with the patient to help him get his wife or brother in. An appreciation for the Indian way, for Indian culture and identity, for closeness to nature and the native healer, have to be appreciated if one wishes to be effective in working on the reservation. An understanding of the system approach alone would be insufficient.

ISSUES IN DISCUSSION

As the groups met to discuss the different programs, the issues and the specifics of issues began to emerge. A recurrent theme in all groups was concern for the people who deliver the services, their recruitment, and their support. Recognition was given to the value and place for a non-formal clinical style characterized by Dr. Gerrish in his presentation. His success in applying this approach as well as his longevity on the reservation were recognized as evidence for the fruitfulness of such an approach. Unfortunately, such professionals are not easily identified. There are no measures to predict behavior with any

reliability. Indian professional people themselves suffer from the same burn-out that non-Indians experience on the reservation. Gayla Twiss, a professional working on the Pine Ridge Reservation, reported that their program had a turnover of 20 indigenous workers in about eight years. Fortunately, most have remained in the community, working for other agencies. Perhaps the use of the mental health system as a training ground was a positive side to an otherwise difficult situation. At this time, in the development of services, it seemed that many participants believed the increased use of indigenous paraprofessionals with on-the-job training was the best solution to the problems of recruitment and cultural distance. They were aware that the motives of individuals accepting mental health positions on the reservation were an important factor in staying power. Lack of knowledge for what motives may predict longevity and effectiveness was also expressed. Some centers support frequent visits to off-reservation centralized services as a positive approach to reducing loneliness and isolation. One participant made the wry comment that such visits with bureaucracy would produce a more favorable attitude toward the peace and flexibility of the reservation.

Bureaucracy and its effects on service delivery was a great concern. People talked about major issues of funding and minor issues of paper forms. Often, the sorts of forms that people are asked to fill out to receive help turn out to be a barrier to service. Boards and administration seem distant and out of touch because consumers are unsure of how people get on the boards, when they meet, and what the responsibilities of the boards are. The differences between the Indian Health Service and the mental health centers, as established by law, cause the same helping tasks to be carried out differently, often by the same professionals. Because Mental Health Centers are required to collect fees and because they have federal and state guidelines to follow, Indian people find them

to be confusing agencies to understand and work with. Some participants thought that two similar parallel systems were being developed to deliver mental health services to Indian people. Discussants believed that service agencies needed to be more flexible and attempt to take the best of different systems. The rehabilitation system was offered as an example of an agency approach which had shown itself to be successful on the reservation.

CHAPTER 2

OUTREACH, CONTRACTING, AND DELIVERING SERVICES

Evaluation of needs, identification of target populations, and outreach are major elements of service delivery. Contracting with tribal groups or other health service providers requires an understanding of existing resources and the means for utilizing those resources. The apparently simple task of providing backup to an existing program can present unique challenges to the community mental health center management and staff when tribal considerations, as well as state and federal guidelines, conflict. Some solutions to these challenges are offered by the following programs.

Frank Lane, Director, Eastern Montana Community Mental Health Center, Miles City, Montana

The Eastern Montana Community Mental Health Center is responsible for providing comprehensive mental health services to the 17 easternmost counties in Montana. This region consists of 50,000 square miles and 100,000 people. Management of the center is the responsibility of the governing board consisting of nine county commissioners and six appointees. There are two counties in the region who have chosen not to participate in the center. Center management decisions are strongly influenced by the social cost of space. There are nine clinical offices and one administrative office in the region.

The present management system for the region began in 1974. With the establishment of a basic philosophy emphasizing respect for cultural differences, a need for continuity and a resource orientation, the center arranged a contract for services with each of the tribes. A social worker skilled in community organization did the ground work between the tribal health boards, the

mental health component of the Indian Health Service, the mental health center, and the other agencies working in the area. Under the contract, the tribes would determine what their needs were and the center would act as a resource for meeting those needs. John Flying, who lived on the reservation, was hired as an indigenous mental health worker and functioned as contact person and case manager. His initial contract has been renewed three times since then. The Tribal Health Board was and is responsible for the selection, training and supervision of the mental health worker. They report the activities of the worker to the center on a monthly basis and are reimbursed. A psychologist from the clinical office in Forsyth commutes on a weekly basis to Lame Deer for consultation with John and a social worker. Workers from both reservations meet regularly at center regional staff meetings for additional inservice training.

Since the establishment of the first contracts, the mental health workers have enlarged their work to include involvement with the Community Support Program for the chronically mentally ill. At the present time, this consists of surveying both reservations and identifying the chronically mentally ill for the purpose of strengthening psycho-social rehabilitation efforts.

Although the center is pleased with the progress of the program and the success of the philosophy it is based upon, a number of issues remain unresolved. Among these are:

1. Continuing prejudicial stereotypes about Indian people are reflected in criticism of the amount of money taken from state and county funds to support work on the reservation. Increases in service are strongly resisted for reasons of cost.

2. Reporting and activity reporting requirements which form the basis of accountability and cost per unit of service evaluation frustrate and alienate Native American consumers and service providers. Many of the clients contacted

on the reservation shun the stigma of becoming a countable "case".

3. Staff turnover is high and burning out is common. Attracting people to the sparsely populated plains of eastern Montana is difficult. Professionals used to complex life styles find the simplicity overwhelming.

4. Because of State policies, it is often difficult to obtain hospital services at the state institution for the chronically mentally ill. District court judges cannot deal with problems that arise on the reservation nor can tribal courts commit individuals to the state hospital. Thus, mental health workers must obtain voluntary commitments without the usual resources available to the non-reservation worker.

5. The requirements for eventual center financial self-sufficiency adds an additional source of management pressure. Without changes in the manner by which services are funded or tax monies allocated, the future for continuation of the reservation service is in doubt. A unification of funding from the Indian Health Services and the center for these services would be a partial resolution of the matter.

Dr. Brian Miracle, Fremont Counseling Service, Lander, Wyoming.

Fremont County, Wyoming, covers about 10,000 square miles and has approximately 40,000 residents. The Wind River Reservation makes up one-third of the county. Originally, the center identified emergency services in hospital and alcohol counseling services in conjunction with the tribal court system as target programs.

The establishment of emergency mental health consultation services in a hospital emergency room setting began with my consultation to the Indian Health Service in 1965. The key to obtaining the emergency services and hospital privileges was the recognition by the local physicians that I had something to

offer that was beyond the scope of their regular activities. In this case, it was psycho-diagnostic skills. Once the program was initiated, it was essential that the emergency room service provider be willing to respond to calls on a 24 hour a day basis, seven days a week. Without a willingness to do that, the service would fail.

The emergency room service provider must have a full knowledge of all the community service providers at his fingertips. He has to recognize that he cannot be all things to all people and make use of other providers. I have discovered that it is important for me not to differentiate between Indians and non-Indians. I see that people, all people, hurt in the same way. Extreme anxiety causes suffering in all people and it is no different for myself or an Indian person. This does not mean that people should not be treated differently. I only have found that it is not helpful for me if I think and act differently toward him because of his Indianness. It is important that the patient feels that you are going to help him without your needing to tell him that you are.

We see a variety of problems in the emergency room which are similar to other emergency rooms across the country. Because of my orientation, I do not count the number of Indian people who use the services. I do know that they experience the same sort of problems that the population as a whole does. People we see are those suffering from acute and chronic alcoholism. We see the suicide attemps; we see those people in acute anxiety attacks, hyperventilating perhaps, or using some other way of expressing their anxiety. We see very few agressive people. This is true nationwide. There are very few aggressive people appearing in emergency rooms. We do a lot of work with known mental patients in cooperation with the state hospital. We offer the opportunity for families with disturbed members to have relief from that individual through the emergency room.

Harold Hopkins, Fremont Counseling Service, Lander, Wyoming.

My work with the treatment of alcohol problems began before I became associated with the mental health center. I had been working on the reservation over the course of eight years, initially with the Department of Public Assistance and Social Services. It became apparent that working out of an office was not going to provide the clients to work with if the problems were to be met. At that time, my offices were with the Indian Public Health Services.

Many people with alcohol-related problems were being seen in the tribal court. Actually, 85 to 95 percent of the people going through the tribal court system were going through for alcohol-related offenses. They were caught in a revolving door process, returning on a regular basis, with few interruptions.

In a meeting with the head tribal judge and his assistant, it was proposed that I offer my services to counsel individuals whom the judges felt were in need of alcohol counseling as they went through the system. Initially, the number of sessions was open-ended. Experience during the counseling sessions revealed that this created too much anxiety on the part of the counselee and was imparing progress. Presently, clients are seen for four sessions.

Individuals are referred while they are still in jail and are seen within two days of their referral. The office is located away from the jail which reduces the impression of coercion. Individuals return for sessions after leaving jail, since to fail to complete the sessions would be disobedience to a court order. The element of pressure from the court, although initially a source of resistance, is quickly reconciled, since the client's anger is from being caught in the system in the first place. By using a personal approach coupled with the client's anger at being caught in the system, it is possible to establish the basis for a working counseling relationship.

Referrals to treatment centers can be an important part of the four session

program. Often, not having a place to live is a part of the alcohol abuse situation. When a living arrangement can be tied in with a treatment program, progress can sometimes be made which would not be possible on an outpatient basis. Such referrals have to be examined to insure that the treatment center does not become a hang-out.

Although no statistics have been kept on the program, my impression, from three days each week in the court, is that those who have been counseled maintain sobriety longer. It also seems that larger numbers of them do not come back to the court.

Paul Meyer, Director, Central Region Comprehensive Program, Pierre, South Dakota.

The Central Region catchment area is located in mid-South Dakota. The region is approximately 300 miles long and 100 miles wide and includes 16 counties. The present population is 75,000. There are five reservations in the region. There are three area advisory boards and one regional governing board with representative membership from the different reservations. Representatives from the Indian community were suggested by the tribal councils, Indian Health Service units and the tribal courts. Through this process we learned that it was easy to find an Indian person willing to serve on the board. An additional stipulation required they also represent an elected or service unit position.

The general approach to service which we have found successful is to approach the IHS unit in the area and offer to supplement or augment their services. We view IHS as having primary service responsibilities in this area. In our experience, the IHS Units are not adequately funded and they do need assistance. Through cooperative arrangements, we have been able to provide a fly-in psychiatrist, psychological services, and other services which our center

needs to be interfacing with IHS on. It is important that this interface occur and that IHS be given the lead responsibility. It is our position that we are dealing with public monies and that we have the responsibility to see that cooperative arrangements work. The center cannot be the primary agency in a host of areas, but it can serve on child protective teams, and it can serve in other cooperative arrangements in the social service system offering services in a supportive fashion.

Danialle Beaumont, Outreach Worker, Capitol Area Counseling, Pierre, South Dakota.

In my work as an outreach worker, I try to keep a number of thoughts in mind. I recognize that each person is an individual; just because they happen to be Indian does not mean that they have to act in a certain way or have all the traditional values. There are a number of customs which influence my work. One custom I recognize is that time is dealt with in terms of natural phenomena. Sharing is a genuine routine way of life. To obtain maturity, it is expected that one must face suffering and have the courage to take life as it is, with a sense of humor. I find a control of emotions and few passionate outbursts over small matters. There is poise, self-containment, and some aloofness as well. An important belief is that everyone is an integral part of the universe with purpose and due respect. From this comes a sense of security and inner fulfillment.

My work requires making home visits, although we do maintain an outreach office on each reservation. People have the choice. I have found that it is helpful if I go to the kitchen door when making home visits. I talk about the children and may play with them. This provides a chance to talk to the parents at the same time. On the particular reservation I serve, there is a dialect

which took some time getting used to. I try to use this when I work there. When I talk with people, I try to sit beside them, not face to face. I try to have no barriers between us. Sometimes there are silences, but I have learned that this is alright. Family information is an important part of the work. Not just information about the client's family, but also information about my own family. Clients like to know that I am a registered member of another reservation. Some people like to know about my education. In working with teenagers I have found that giving them a token to show sincerity is often appropriate. My work is mostly with women and children, although I have a colleague who is male and works mostly with men.

One of our program goals is to develop groups. We want to give members an opportunity to share their feelings of joy and intimacy as well as their problems with one another. We believe this will provide means for informally supporting one another.

Roger Hornby, Rosebud Guidance Center, Central Region Comprehensive Program

In the catchment area of our mental health center, there is a four county area, one of which is the Rosebud Indian Reservation. Surrounding the reservation is a number of small communities of 25 to 50 people. An outreach worker does most of the contact with these communities and has some limited contacts on the reservation. Our approach in the development of services was to develop a positive attitude of cooperation with the IHS. This proved easy to do since there were services which IHS felt it was not providing as well as might be if both agencies worked together. The center's approach was to help the IHS provide services which they felt they were not providing.

There are two children's homes on the reservation. One, an entity of the Rosebud Sioux tribe, has a contract with the center. The center provides direct

services to some of the residents as well as staff training for the employees. The goals of this work are to help the staff and residents meet the abrasions of their circumstances as well as possible. As a result of this work, the center is negotiating with the second home for provision of similar services.

To meet the problems of glue sniffing and huffing, the center developed a program that has been well received. As a consequence of offering the program to groups on and off the reservation, there has been an increase in requests for strengthening resources and programming for dealing with the problem. At a recent conference on alcoholism, the center assisted people from the reservation in attending and expressing their concerns. With the help of the White Buffalo Calf Women's Society, the center has been active in the development of domestic violence facilities. Presently, the center is attempting to provide services to specific issues. We do not feel it is wise to offer answers to difficult problems that do not have ready solutions where we might appear as saviors. In our experience, there are two kinds of white people who come to the reservation: one is a soul saver and the other is a kind of "Indian-in-the-Making". Neither image receives much credibility on the reservation and the center guards against the possibility in its work.

Erwin Bitz, Director, Memorial Mental Health Center, Mandan, North Dakota

Our center is located in a rural area with a total population between 102,000 and 112,000 people. There are nine counties that cover an area 142 by 132 miles. The Standing Rock Reservation is located in our region and over the years we have provided services on a more or less sporadic basis there. Within the last three years, the region has seen a development of its coal resources and the impact is not completely known. In addition, federal funding for the center has dropped to near zero, staff have been reduced from a high of 63 to a

present group of 29. Efforts to replace lost funds through grants and legislative support have been unsuccessful. Notwithstanding these changes, we are trying to learn from our experiences and cope more effectively through planning with the people in our area. The process of reducing services was difficult and we met with a lot of criticism from all quarters.

Our initial approach had been to do "innovative" work "for" the tribal people. With the reduction of funds, we could no longer "do for" them. Necessity required that we ask them how best the center could help them to accomplish what they wanted within the restricted resources we had. Aggressive leadership in the tribal social services responded to this approach with firm planning and requests. By turning over the responsibility to the tribe, the center gave up the possibility of dreamily trying to replenish its coffers by writing another grant proposal to do things for the Indians. The ball was passed to the tribe and they came up with a proposal of what they wanted and how we, through the center, could help them in a realistic way. At the center, we don't feel that we have copped out on our responsibility, but have finally discovered a solution which has real potential for serving the Indian population in our region.

Dr. Peter Chommie, formerly the center program evaluator and quality assurance person, will tell you more about the resulting program. Since the tribe got its grant, they recruited Pete away from the center. Other staff have also been recruited and the tribe now has double the amount of service personnel to serve its population than the center has to serve its entire catchment area. We are pleased at this and the resulting improvement and growth in service on the reservation.

Dr. Peter Chommie, Mandan, North Dakota

My present position is best described as a consultant to the Standing Rock

Reservation. The reservation is unique because it is located in both North and South Dakota. There are approximately 5,600 Indian people living on the reservation about equally divided between both states. An additional 5,000 non-Indian people also live on the reservation. Of the Indian people, 65% are currently below the poverty level. The unemployment rate is 56% in the summers and jumps to 70% in the winters. Of the population, 47% is 16 years of age or below. The average life span is 45 years which accounts in part for the high proportion of younger people. The infant mortality rate is presently 15 per 1,000 live births, and 27 post-natal deaths per 1,000 live births.

Being located in two states is a source of additional problems. Among these are lower commodity rates between states, different AFDC payments, direct BIA assistance differences, fragmentation or absence of child welfare service support, and no Title XX funds because of absent matching funds between states. The tribe's solution to this situation is unique and a landmark for the country.

The tribe has proposed to the Department of Health, Education and Welfare that the Standing Rock Reservation be declared the Fifty-First State for purposes of social services. They are asking for direct federal funding with no state interference. The proposal has two parts. The first asks the federal government to determine the feasibility of accepting full responsibility for the delivery of federally supported services on the Standing Rock Reservation. The second part seeks to demonstrate the tribe's ability to implement and capably deliver supported federal services without state interference. The concept of direct funding originates in the nature of treaty relationships. Treaties have never included states. Consequently, state-tribal relationships have been ambiguous. The tribe has treaties with Washington and does not want state money. This second part is very much in the spirit of the Indian Self-Determination and Education Act passed by the Congress in 1974.

We understand that the proposal is receiving serious consideration since both states have backed the proposal until now. Consideration of some uncertainties for the states is being negotiated since the question of how much federal contributions to states may be cut is at issue. Health, Education and Welfare have declared that they are not willing to deal with each of the 200 reservations as separate states. They will, however, deal with the seven reservations which do cross state boundaries as Standing Rock does. Additional issues which must be confronted include local matching sources, length of time to implement services and whether the Secretary of Health, Education and Welfare can waive responsibility of the states for delivery of services.

Standing Rock has taken major strides in meeting human service needs. Through mental health center involvement, technical assistance in the development of grant proposal writing was initiated. A series of related grants were obtained by the tribe. The first, from the Office of Human Development, was initiated in 1977 with the objective of establishing a comprehensive social services plan. This grant would develop tribal capacity to implement its own human service delivery system, teach the tribe the process of needs assessment for future use and serve as a framework for future grants.

Using a community forum approach, our small staff went into seven local districts. They got on different agendas and made a presentation about the grant and its objectives. Community input was obtained from a questionnaire distributed at the meeting which had been developed by the staff with little direct input from me. Using the Key Informant Technique, important members of service staffs already working on the reservation provided additional information which served as a basis for future grant activity.

The first grant was for $100,000 and funded the Executive Director, Administrative Assistant, secretary and one or two other director's positions.

A second grant with the Office of Human Development provided funds to establish a day care component, part of the employee assistance, youth services, a data analysis segment, and part of family and children's services. The Department of Agriculture funded a Well Infant Clinic component which has also served as a case finding unit. The BIA was persuaded to contract with the tribe to provide a protective service. IHS has partially funded an employees' assistance program from a $200,000 grant. In just over one year, the tribe has gone from no money in social service dollars to over one million dollars, and the possibilities remain for future projects. One major consideration is service for the elderly. A proposal currently under review would pay elderly tribal members to go into the daycare program and serve as cultural transmitters. Staffing in the human service areas has reached 55, of which only three are non-Indian. Our commitment is to the provision of a process to the tribe and then to get out, leaving the tribe to use the process for their purposes.

One component of the process is evaluation. An independent third party is involved in evaluation. The results of this procedure will provide support for the larger issues of direct funding to the reservation. As a part of overall comprehensive social services programming, a collaborative effort between the tribe and the mental health center in Mandan would study the use of resources which already exist on the reservation such as traditional healers. These resources would be involved as an alternative to traditionaal mental health services.

Dr. Bill Taylor, Northcentral Montana Community Mental Health Center, Great Falls, Montana, and

Dr. Murton McCluskey, Title IV Indian Education Program, Great Falls Public Schools, Great Falls, Montana

Our purpose in this presentation is to describe how two separate programs with different objectives and needs developed a working relationship which has enhanced the scope and effectiveness of both programs. The basis for the development of interdependent services originated as a consultation and education effort on the part of the mental health center and inservice training needs for the Title IV staff. On the basis of a one-day workshop on the use of family counseling techniques and community resources, a more comprehensive training unit was designed to meet the specific needs of home school coordinators and others working the Title I and IV programs. Since then, the unit has been presented five times in the past two years, both in Great Falls, as part of the State Indian Education Conference, and on the Flathead Reservation. Staff from the mental health center and the Indian Education Program cooperate in the presentation of the unit.

The Title IV Indian Education Program serves about 1,000 children of the 16,000 in the Great Falls school system. The position of program director was established about four years ago as the result of a civil rights mandate against the school system. Among the charges leveled against the system was lack of communication between the Great Falls public schools and the Indian community. One of the challenges which had to be met was determining who was the Indian community. There are presently students from 38 tribes in the school system and almost as many different life styles. Under these circumstances, we have felt that it is presumptuous to say that students should be aware of "the" Indian culture. Our objective is to provide students and teachers with certain forms of the Indian culture. We accomplish this through the use of Indian people who come into the schools for that purpose.

An additional charge of the Civil Rights Office was that the school system had an unusually high dropout rate among Indian children. In a discussion with

members of the community, it was decided that if anything were to be done, the earlier ages would have to be targeted first. The success of this approach is reflected in the greater numbers of Indian children attending school and continuing further in the system. Although we still have some children dropping out at an early age, there are currently 550% more Indian children in the high schools than was the case four years ago. We have had 300% more Indian students graduate than before. These kinds of changes have been the result of the efforts of the resource people and the home-school coordinators who work in the schools and with the children and their families.

We believe the teacher is a significant part of the solution of the high and early dropout rate for Indian children in the schools. Teachers and counselors must understand that Indian children come from very difficult environments. Understanding this differentness enables tachers to see that the usual solutions do not always work. For white middle class teachers from an academically successful background, the problems of Indian children can be hard to understand. Not too long ago we had the problem of a student who flunked junior high science. He was given the choice of completing the science requirement by taking either biology or chemistry. To a student who could not read the introduction to the book, this was not a very optimistic approach for getting through.

Many students just want to get the credit so they can go to Vo-Tech and take auto mechanics. We have changed some of the programs and adjusted the curriculum to better meet the needs of more children. Many teachers are now changing their methods and ways of dealing with these children. Most teachers are very receptive if they know what is happening. If teachers can be made to understand the problems of these children, they are willing to make an adjustment. If adjustments in understanding and program are not made, these children

are doomed to fail.

When a youngster is having problems with the three "R's" in the elementary grades, we look further. The problem may be just the tip of the iceberg. Often, the academic difficulties are the results of other causes of a socio-economic, legal or psychological nature. To say a child is failing because he did not know his times tables is a very shallow view. Adjustments can be made in the wider circle of the child's world with the help of centers such as the mental health program in Great Falls, and what we are able to accomplish together.

The mental health center was aware that many of the young people who were being dropped from school for reason of truancy often found their way into the juvenile justice system. Frequently, they were referred to the center for services. In response to the interdependent nature of many of the problems these youngsters faced, a cooperative endeavor, the Youth Development Center, was discussed among the most involved agencies, e.g., Social Services, Youth Court Services, secondary schools curriculum, and special education. The objective of the program was to pool the resources of the various agencies to present a comprehensive treatment program which minimized or eliminated duplication of services and maximized cooperative use of staff and space. Shortly after the group began meeting, it was apparent that many of the young people who were being considered for the program were Native Americans. If the proposed program were to work effectively with the Indian children, then representatives of the Indian Education Program would need to be a part of the Center programs as they developed. We decided that a staff member from Indian Education would attend each planning session. As a result, not only center professionals but also staff from other agencies began talking about Indian children in a way that was not common previously. The earlier attitude of, "Forget it, you can't do

anything about them," is being replaced by one of, "Wait, this isn't a total loss, what can we do?" With home-school coordinators representing Indian interests and resources, something can be done.

A major dimension of the Indian Education Program developed out of some of the original surveys. In one of the studies, 100 Indian people who had dropped out of school in the previous ten years were identified. They were interviewed to determine why they had dropped out of school and what the schools would have to do if they were to return. Many of the reasons given for dropping out were similar to those found for non-Indians, i.e., did not like a teacher, not meaningful, had to get a job. An additional factor was also present for the Indian student that was not identified for the non-Indian student. Indians felt badly about who they were as an Indian person and who they were in the shools as an Indian person. The enhancement of self-image and self-concept has been one of the most important parts of the program ever since.

If Indian children drop out of school at an early age, chances are they will drop out of society at an early age. Expending more time and money on the Indian child before he is ten will determine what we will not have to spend on him when he is twenty-five. We spend a large proportion of our time providing things for teachers, parents and children. We help parents understand the children more, help teachers work with them, and help children feel good about who they are and where they are in the school system. There is now a changing attitude in the high schools. Indian young people are involved in things related to curricular and extra-curricular activities that Indian children traditionally never participated in. School is not just for the three "R's"; it's for activities, too.

The role of the mental health center in this process is to provide the atmosphere and setting in which those in greater need emotionally can find the

opportunities to master the classroom behavioral skills necessary for survival. This is the function of the Youth Development Program. With the precedent established there for alternative learning experiences, a tradition of failure, delinquency and disturbance can be broken. One cooperative program illustrates the nature of our current interagency service delivery.

A number of youngsters in a self-concept enhancement program developed by the Indian Education Program were identified as in need of therapeutic as well as educational experiences. The center employed one of the home-school coordinators for a pilot project to enlist the cooperation of the children's families and to facilitate the attendance of the children in the center planned activities. An active program of encounter activities, communication exercises and self-awareness games was integrated with a recreational therapy group program during the summer. Children went rafting, hiking and to other planned events in the community in addition to their regularly scheduled self-concept enhancement program. Because of the time limited nature of the program, it was decided to combine this group of eight Indian children with a group of eight non-Indian children with similar needs. The result has been exciting. Many of the children had an opportunity to appreciate themselves in a new and adventurous way. Activity is the key to enlarged self-appreciation for younger children. They also had an opportunity to encounter children of another race and culture in a manner which tended to break down stereotypes and prejudices on both sides. The contribution of the Indian Education home-school coordinator, as a regular therapist in the group, helped to make the group truly cooperative. As a result of the experience with this program, the center has added an Indian person to the treatment staff of the Youth and Family Services Program.

ISSUES IN DISCUSSION

Discussion among the groups focused on two major areas, one concerned with

management and center direction as an outcome of legislative change, and a broader issue concerned with the relationship of an educational system to a minority culture. Of concern to the discussants was the impact of the Indian Self Determination Act upon the traditional roles and relationships between Indian Health Service and the centers. Those participants from the Indian Health Service indicated that they were turning over the management of health services to the tribal governments. Under these circumstances, the relations of the centers to the reservations would become more individualized and less centralized for policy decisions.

The nature of relationships between governing boards and centers was also discussed in relation to the establishment of services to Indian people. Discussants were accutely aware of the lack of a clear pattern to use as a standard for such work as well as the need for more direction and information. One discussant expressed the opinion that centers and interagency relationships grew and continued as a function of the individual personality of the director. Such experiences and perceptions contribute to the belief that no clear system for the delivery of services or management of centers exists.

Concern was expressed for the relationship of education as a system to the Indian community. Although it was recognized that education was the traditional means used by minority groups to become members of the majority culture, the issue of racism was a complicating factor. Some felt that this precluded anonymity. Concern was expressed that education needed to involve itself with the development of survival skills as well as the traditional basic curriculum. A consensus developed around the belief that the educational system as presently established was completely foreign to the traditional Indian community. Whether such a system could ever effectively carry out its role under such circumstances was raised but left unanswered.

CHAPTER 3

CHANGING STEREOTYPES AND CONFRONTING PREJUDICE

Educational support and consultation are a large part of prevention work. Programs have been developed to provide inservice training for staff and cultural activities for the community. The development of an enlarged sense of identity through positively oriented activities and the use of specially trained staff and resources are also elements of a preventive mental health program. When treatment and prevention can be integrated in one program, benefits are multiplied further. The efforts discussed below suggest some of the rich variety possible in dealing with prejudice and racism as one element of preventive mental health work.

Bill Walsh, West River Community Mental Health Center, Rapid City, South Dakota, and

Phyllis Cross, IHS

Prejudice and its effects are as much a mental health problem as are the traditional concerns of the mental health movement toward the elimination and treatment of mental illness. Our experiences in confronting prejudice indicate that it must be met in the center itself as well as in the community. One of our most effective programs is an inservice training program for the staff at the center. The program was initiated when we learned that there was concern on the part of some women in the community that Indian people did not feel comfortable going to the center. Contact between the center and the Indian population in the community had been minimal in the past. Many of the staff members had very little experience or contact with Native Americans as a part of their background or training.

We saw this as an opportunity for people from the Indian community to come to the Center on a twice monthly basis, for two hours, to share their cultural values and discuss some of the problems they were running into. The program has been running for over two months and some rewarding outcomes are appearing. A genuine dialogue has developed between the staff and the Indian people. Such things as, "I have always heard this about Indian people. Is it true?", are being discussed. The atmosphere is not one of confrontation, but more a sharing of feelings. This arrangement has allowed a great deal of collaboration between the Indian Health Service and the center. As a result, several Indian leaders in the community have been contacted who are specialists within their own fields. A young man involved with the Black Hills Legal Services was a recent speaker who talked from his own experiences.

The image of Indian people presented through newspapers and television is a major source of stereotyping. A common white viewpoint, perhaps due to the isolation of the Indian people, is simply that of a drunk Indian. When Indian people came into the small South Dakota towns, it was as a beggar. Often, the following day's paper carried an account of the Indian person being thrown into jail for drinking. Much of our work is attempting to overcome that type of image, which is a persistent one. When we see newspaper articles which reflect this orientation, we go in and discuss the articles with the writers and editors who produce them. These informal meetings have been very productive. Recently, when an Indian girl was raped by a policeman in Rapid City, the newspaper called to consider what a fairminded approach to the situation would be. They were seeking background information. This kind of collaboration is most beneficial in a city that has known ten years of militant action and civil rights activity.

Many white people cannot see the offensiveness of these articles in the manner they are written. This is frequently a source of amazement and anger to

Indian people. If articles which reflected stereotyped thinking were changed around to say white people instead of Indians, many white people would not be happy with it. Centers can play an essential role in dealing with the media. Often newspapers and television news people are less responsive to Indian people protesting their image in the news. Centers can be advocates for Indians in going to the media since many Indian people feel that if they went, they would not be listened to. When white professionals go, they listen.

A further outgrowth of the inservice training program has been a multi-faceted community action program which is based upon the collaborative efforts of the center and the IHS. Utilizing a consultation and education approach, the center has become aware of the emerging leaders within the Indian community.

Indian Health Service has known many people who were leaders in the area who now want to turn over leadership functions to the young people, and it is important that these young leaders develop the readiness for assuming an advocacy role. When these young leaders were asked how the center could be of help to them, they answered, "Give us some support!" In response to this, a simple but essential step was taken. Each Wednesday, people from both agencies together with a number of the young leaders go to one of the better restaurants in town. They occupy one of the more visible locations in the room and meet and interact with different members of the white community who happen by or are invited. The informality provides an opportunity for good sharing of concerns to all. Community leaders who come by are introduced and the meetings provide a personal quality to the experience. When people get to know one another on a personal basis, some of the tension inherent in business relations is reduced. Even though white people and Indian people live in the same town, they live in isolation. Finding a common ground that provides a comfortable meeting place is essential to removing stereotypes.

Quick thinking averts injury

Quick thinking on the part of his girlfriend saved a Martin man from possible injury after they stopped in Scenic Saturday afternoon.

Jan Able and his girlfriend were on their way to Rapid City when Able was confronted by an Indian man when he stopped in Scenic to pick up some beer, according to the Pennington County Sheriff's Department.

The Indian, telling Able he was going to "kick (his) ass" because he was a white man, took a swing at him and tried to kick him, according to Able.

Able ran back to his car which his girlfriend had started and jumped into the passenger's seat as two other Indians tried to circle him, according to the sheriff's report.

One Indian reportedly grabbed a side window of the car, breaking it before the couple was able to drive away.

Sheriff Mel Larson said his department also received reports that at least one Indian was shooting at motorists on the Scenic street, but witnesses would not talk to sheriff's deputies.

Canadian tourism

Of the 33.3 million visitors to Canada in 1978, 31.6 million were from the United States.

Pine Ridge man struck by car

A Pine Ridge man is in good condition after he was struck by a car at 2 p.m. Saturday at the Dark Canyon entrance.

David "Guy" Red Cloud, 33, was standing on the road when he was struck by a car driven by 19-year-old Darcy DeWayne Ball, Rapid City, according to the Highway Patrol accident report.

The accident occurred during an altercation between the passengers in the Ball vehicle and a group of Indians, according to the Pennington County Sheriff's Department which was also called to the scene.

The investigating sheriff's deputy reported that details were sketchy because many of the persons involved refused to give any information to him.

A resident said the group had been stopping motorists and asking for money.

Ball left the scene of the accident and flagged down a Rapid City police car to report the incident, according to the Sheriff's Department. Ball told the investigating officer he had tried to call the police, but left the scene after being confronted by an Indian man.

Red Cloud was taken to Rapid City Regional Hospital East.

RCJ-7-2-79-

Badger trial begins

The murder trial of a Pine Ridge man began its second day Tuesday morning in U. S. District Court in Rapid City.

Opening statements were made in Charles Ray Badger's trial Tuesday after the jury had been selected Monday afternoon.

Badger is charged with second degree murder in the Nov. 17, 1978, beating death of Raymond Pawnee Leggins at Pine Ridge. Three others are charged under separate indictments in connection with the murder.

RCJ 7-10-79

In talking with the young leaders in the Native American community, we found they had a strong need for reassurance. These people often see themselves as having to be forceful and lacking permission to show any weakness. The necessity for direct teaching of leadership skills is evident and plans are underway to provide this. There is a need for the development of skills in dealing with the media and doing community organization work. The development of a positive philosophy rather than a confrontive one is emphasized. When these needs can be fulfilled, the problems of a "burnout" are minimized.

Community action councils are also effective devices for allowing a great deal of honesty. Dr. McCluskey reported that in Great Falls, the Indian Action Council had 27 members of which 13 were non-Indians. Members of this committee consist of the Mayor, City Manager, Chief of Police, Sheriff, and City and County Commissioners. If a problem develops with the Department of Welfare, the Head of Welfare will be invited to sit on the board. Indian people on the committee are both leaders and private citizens who reflect issues from the community. A similar board in Rapid City allows honesty to develop among the different groups. People on either side of a position cannot get away with prejudicial pictures of one another. Such a group fosters accountability and responsibility. It meets on a monthly basis and confronts issues which effect everyone. A current issue concerns the management of slum housing and will include landlords from the neighborhood.

The implication that a mental health center would be involved in the initiation or support of an advocacy group was opened as a discussion issue. At West River, the center is very much involved in the program, yet it is seen as cooperative with the Indian Health Service. As a result, individuals from these agencies acted as a team and saw this activity as one aspect of the center's consultation and education function. No clear consensus was achieved by the

group around the issue of advocacy.

In collaboration with IHS, West River Center has opened a dialogue with educators from the post secondary schools in the area. There is a state college, a school of mines and two Indian colleges in the region. Using a Humanities grant, a film festival is in planning, built around a series of films dealing with different aspects of ethnic experience. This is not simply a "let us Anglos learn about Indian culture" program, but a rare opportunity for both whites and Indians to learn something about one another's ethnicity through the relatively neutral ground of film. Prior experience with this approach on the Pine Ridge Reservation was extremely successful. The aim of the festival is to get people together to talk about their common experience of ethnicity rather than the differentness of their antagonisms. There is much more sameness in our differences than many people realize. Such an approach strengthens the self-image of people, not just that of the Indian people.

Gayla Twiss, Pine Ridge Reservation, and
Jim Hagel, West River Center

The performance of a mental health center must conform to the history and needs of the people who will be the recipients of its service. Although that is almost a truism, making it work is a challenge. We believe our experiences are illustrative of many of the basic situations which may be encountered in the development of services on a reservation.

The Pine Ridge program began as a pilot project of the Indian Health Service in 1964. The program was begun at the request of tribal and community leaders who were concerned about the incidence of suicide attempts among the young people and the extent of alcohol-related problems on the reservation. Before the beginning of the program in 1965, there had been one attempt to

deliver mental health services to Indian people. This program, located in the southwest, served a number of tribes. The Pine Ridge program serves one specific tribe on one reservation, the second largest in the United States.

From 1964 until approximately three years ago, the program operated on the basis of an original needs assessment done at that time. This research defined problems, described their extent, and provided a map of how they could best be met to help the tribe. A lot of exciting things happened in the course of developing resources. There were problems in continuity of service delivery because of frequent changes in professional staff. Often, services would be halted for three or four months until replacements could be obtained. A study of the Navaho Reservation model revealed that driver-interpreters were the professional staff out there. They were actually doing much of the therapy. They were interpreting the "shrink" jargon into plain "Navaho English". They were able to take shortcuts and get to the problem itself. They did not have to take long sessions to establish rapport and trust. Pine Ridge program decided to hire and train cultural specialists who would interpret to professionals those quaint behaviors and oddities in the Indian culture sometimes mistaken for psychopathology. Many times, Indian people were described as schizophrenic mainly because of symptoms of withdrawal which were present in almost every situation. The Indian workers tried to interpret these things to the professional staff, while at the same time the Indian workers were being given the training to do therapy themselves. When funding was cut back, people began leaving the program and it was impossible to keep the positions filled. It was at this point that the West River Center approached the tribe. The staff of the Pine Ridge program consisted of one psychologist and three mental health technicians who had been with the program for quite some time. This team had been reduced to providing basic services and crises intervention on a day and night basis. They were at the

point of burning out.

At the same time, a reassessment of the Pine Ridge program was underway. This assessment considered both tribal events and our experience with the delivery of service. We believed that mental health services to Indians were best provided by Indians. Mental health people, mainly researchers, had been coming on the reservation for many years, doing their thing, going away and not leaving anything behind. As a result, the tribe had passed a resolution that no type of research, including needs assessment, was to be done without their knowledge. It was during this time period that the trib experienced the events associated with the confrontation at Wounded Knee. Many outsiders came in and totally disrupted the reservation which seemed to produce much more trouble than the confrontation was worth. As a consequence, the tribe began to tighten up toward the outside world. It was a particularly touchy time, and just not right to bring strangers who were non-Indians to the reservation to provide mental health services. We felt it was important that West River personnel be under the protection of the Pine Ridge program.

The Pine Ridge program is responsive to the tribe. We are aware of what the problems are and also of the extent of our own power. Even though we are trusted by the tribe to do what we know is best, being Indian does not protect us. Although we have been with the program for almost 11 years, an error would eliminate us just as much as i would a white person. Our tribal chairman tells us that anytime we go to the state for money, we are undermining him. Federal money is all right, but not state. This further complicated our relations with West River Center. In all, there are 90 different agencies on the reservation, none of whom are coordinated and many of whom overlap in their efforts.

As negotiations began with West River, Ms. Twiss left the program. West River had plans for a reservation program at that time. They began by talking

with those whom they had identified as reservation leaders and a number of areas were identified as lacking in service. Our observations were similar to those made by the Pine Ridge staff. There were 3,600 children attending BIA schools on the reservation with no psychological services available. Drug-related problems were also evident. Pre-school children were sniffing glue and paint, and there were tremendous alcohol problems. The whole situation was overwhelming. The only service it appeared there would be time for would be crisis intervention.

As a part of the planning process, we at West River dealt with a number of agencies on an independent basis. Since many of the programs were not coordinated, this seemed like a logical process. The process of establishing independent alliances with different agencies was a reflection of our somewhat naive approach of walking into the environment and saying, "Here we are." We became very discouraged and wondered who really represented the Indian people. At this point, we began to deal with the acting director of the Indian Health Service. Our salvage efforts were stumbling at first, but led to very good dialogue between us. We learned to work with one agency and coordinate all services through the one umbrella agency. We came to appreciate that development of services was going to have to be very slow. People could not just be placed on the reservation as we had originally assumed. At one point, we thought we could contract some staff to the Indian Health Service which would permit our input as facilitator while retaining low visibility. We quickly learned that IHS cannot have direct contractual funds given to them. There was just no provision for it.

At this point, we have developed what appears to be a good working document. The agreement calls for an allied working relationship including accountability, quality assurance program, and office space. There is irect advisory group input from the Tribal Health Board. The negotiations have been a long,

difficult process, and staff have not set foot on the reservation on a permanent residential basis. We have mutual consultation and education efforts between agencies which were discussed earlier. From our experience with the Pine Ridge and West River programs, we have learned that people who work in mental health centers can be valuable as advocates for Indian people. Doors are open to them which are not open to minorities. We have also found through the years that it is a waste of time to try to change the thinking of white people about racism. Energy needs to be directed toward the person who is being treated with prejudice to help them to cope with this. This is especially true for the young people and children. They need help in learning that they do not need to waste their energy feeling angry and frustrated....they need to know that there are other ways to deal with prejudice.

Dr. Murton McCluskey, Title IV Indian Education Program, Great Falls Public Schools

The essential element of our program is the dedication and commitment of the staff. The bulk of our staff are the home-school coordinators. The home-school coordinators are an extension of the school system doing things which traditionally have not been school tasks. At the present time, our staff consists of six coordinators who provide activities and services ranging from getting scholarships to getting groceries. Although a large part of their work is in direct service to the Indian children in the school system, they also provide services to the teaching staff of the school system and to other agencies in the community who work with Indian children. They meet the challenge of prejudicial stereotypes on a day to day basis. Last year they made a total of 7,532 contacts on behalf of children. Most of them have no concept of a normal working day. They have learned that many of the problems that have existed with

the children are familial as well as academic. When there are academic problems, they work with the schools and classroom teachers to develop treatment plans or effect change. Many times, family problems are a factor and that is when cooperation with our agencies is important. In our work with the mental health center, we have served as co-therapists, as "leg men" making home visits, and as consultants representing a particular cultural consciousness. The sharing that comes from this association is a benefit to both staffs. For those who are interested in a more detailed description of the work of the home-school coordinators, a handbook is available from my office.

In addition to the direct services, our program provides materials for teachers in the classroom. Our resource room contains material for use in the classroom by the teacher and also materials for the teacher about Indian people and the issues of importance to them. This inservice function may be as important as the materials for use in the classroom. At the present time, there are 26 schools in the Great Falls system and our program goes into each one at least once a year. Schools with heavier Indian populations are visited on a more regular basis. It is our belief that when someone works with individuals from a different culture and background than their own, they need to acquire techniques for working with those individuals which will be most effective. We do not believe that what works for one will always work for all.

A major part of my own educational experience was acquired in a boarding school on a reservation. As a product of BIA schooling, I developed a very callous and accepting attitude toward the procedures and techniques used there. In my schooling, all behavior was treated as deviant behavior and discipline was all the same. Perhaps as a result, I have little time for poor teachers and counselors. In my opinion, they are the worst form of child abuse. Some terrible scarring is done with techniques that are questionable at best. It is

our desire to provide good experiences for children. Without adequate role models, Indian children develop limited expectations for themselves that perpetuate the self-fulfilling prophesy of the stereotyped Indian. For this reason, we believe it is imperative that Indian people be involved in all the professions. We believe we have been effective in this regard with the high schools. The attitude is changing and the younger children are learning that there is a vehicle where they can "make it". It is all part of what appears to be a cheerleading process.

We, too, have learned that children do not handle prejudice very well. A major component of our effort is giving positive information to children so they do not grow up feeling something is wrong with them. Teachers are an important part of this process. Little children must not be exposed to prejudices and negative attitudes. The responsibility for this lies with parents, but it also lies with the schools. For this reason, our resource room contains materials which relate to counseling and attitude development as well as the more traditional cultural information. These materials are available in films, books and consumable forms for the widest possible use by teachers, parents and children. An additional function of the resource room is to provide qualfied Indian people to go into the schools with information on different aspects of the Indian culture. We have Indian students from the college who help us in this work. They teach such things as food preparation, cooking, beadwork, and crafts.

The issue of burnout is one that must be confronted. It is a luxury we have little time to think of, however. Out of pure necessity, and consistent with our program, we are all busy in the community. Presently, I serve on ten different boards, judge beauty contests, boxing matches, and talent shows. I will speak to anyone who wants someone to come in to speak, in the evenings and on Saturday. It is very important that we be able to pass on to willing people

in the community the information they need to resist prejudicial stereotyping. The need to continually defend the lifestyle of Indian people is perhaps the one aspect of our work which is most tiring. In my twenty years in education, I have seen tremendous changes and some real progress has been made. Many people have no idea of the atmosphere that existed in the schools before the money was made available to provide programs such as Title IV, which have made some of that change possible. Without the willingness of both whites and Indians to make some changes, progress would not occur.

Les Eddards, Activities Worker, New Directions Center, Northcentral Montana Community Mental Health Center, Great Falls, Montana.

The program I am going to describe is unique; it combines two efforts which seem incompatible, into one. The outcome is both therapeutic and educational. Basically, I take Indian culture and ideas around to the school children. When I first began doing this, I was not working at the mental health center, but since then I have begun including members of the New Directions Center who are Indian people. Our members are basically individuals who are described as chronically emotionally disturbed. Many have spent years in the state hospital and show the characteristics of institutionalized life. Our current group of Indian people consists of Gros Venture, Crow and Cree.

When I first thought of including members in my visits to the schools, some of them were ashamed to say they were Indian. Some did not know much about their culture. I started a group for Indian people and have made use of materials I have gotten from Dr. McCluskey's resource room. Since then, we have become very popular; sometimes we are out more than once a week. The program consists of singing, dancing and a display of crafts and utensils. We involve the children in the dancing and allow them to handle the utensils. We wear

Indian clothing and jewelry, and describe the food and dress the Indians used to wear. We show how they tanned the leather, made weapons, and talk about their trade. Afterwards, there is a question and answer period.

Many of the kids still think Indians live in teepees on reservations, hunt with bows and arrows and take scalps. We try to give them a more realistic picture of Indian life then and now. I have had Indian children in the classroom stand up and say, "I wasn't proud to be an Indian until you came down and talked to us." Some will say, "I got a little bit of Indian in me, should I be proud?" I tell them they should be proud of whatever they are. We have sometimes been invited to come back into the same classroom later in the year. One time, we were invited to come back three days later and some of the parents were there. One parent in the room was Indian and she said she was glad we had come, and she was pleased with the program.

My background is Chickasaw-Cree, and I went to the schools in Great Falls. When I got to junior high, there were 18 to 23 Indians. I worked in the lunch room, swept floors, policed the school grounds, and went to three classes a day. The only thing the school made sure I attended was football. I was kicked out of the seventh grade 27 times, mostly because I was not paying attention. If I had the chance that Indian and white kids are having in school today, I might have been a professional. I am not, however, dissatisfied with my life. I have had a number of good jobs. At one time, I managed three movie theaters. I lost that job when they found out that I couldn't read or write. I still hold the fact that I can't read and write against the school system. I believe they could have been of more help to me in that respect. I feel it is important to get a good education. The mental health center has given me an opportunity to make a contribution and I do a good job there. My work takes me into schools as well as the center, with Indian people and white people. There are oppor-

tunities for our group all of the time. We make jewelry, go out on jobs in the community, and develop new and improved work habits. We will have a booth at the fair where we will be selling some of our work, demonstrating crafts, and showing slides of some of our activities about Indian culture.

ISSUES IN DISCUSSION

Two major considerations were discussed by the group. As in the earlier discussions, no clear answers were forthcoming, although a general consensus was achieved around problems of which agency is most effective in facilitating the development of services. It seemed clear that the mental health centers in themselves were not appropriate to carry sole responsibility for initiating or maintaining mental health services for Indian people. Indian Health Service was identified as having considerable effectiveness in providing services on the reservations in South Dakota. However, there was recognition that this might not be the case in other regions. In the Waterton area, it seemed better to deal with the tribal health council. Such seemed to be also the case for the Pine Ridge program as well. There, the tribe feels the federal government is responsible for health services. At Pine Ridge, the tribe was under a lot of pressure to take advantage of all the opportunities available, although many times they were not fully prepared for the consequences. Ms. Twiss said her program was in a unique position of responsibility of speaking for the tribe, because the tribe did not have time for everything and their responsibilities were large. At this time, they had little time to devote to social problems. In one participant's experience, the tribal council had many opportunities, but the addition of complicating limitations through rules and numbers of people who became involved compromised working through that group.

The question of who should work with the media was clearly important to the

participants. Division occurred over who should take the lead in that work. Some felt that the Indian people themselves should react to the often prejudicial stereotypes presented an by so doing, force recognition and a reaction from the media. Not everyone felt that they were effective in this work; thus, it should depend upon effectiveness rather than race in matter of approach. Ms. Twiss acknowledged the validity of this position and anticipated that some day the white power structure would listen to the Indian. It was not her intention to present a completely negative picture. She believed if one were interested in change now, the media was not prepared to listen to the Indian. She felt it was hopeless for an Indian to fight the system as they are treated differently. In order to effect some power changes in the present, Indian people must use their white front men to do it for them. Others felt that the most effective approach would be to help the Indian people to do it rather than to do it for them. There was a general appreciation of the need for collaborative effort. The problems of institutional racism are most responsive to efforts at solution which come through the existing power structure rather than through minority groups themselves. When solutions are collaborative, they have a greater likelihood of being successful and not causes of further problems which perpetuate the stereotyping process.

CHAPTER 4

FURTHER CONSIDERATIONS

The relationship between mental health centers and Native American people is a changing one. The establishment of tribal self-determination as an element of federal policy and proposed changes in the Mental Health Act will both contribute to the challenges facing both groups in the coming decade. Our experiences with working together in the past have not been the most rewarding for either group, yet, as the conferees have shown, there are many indications of progress and no shortage of opportunities for growth. In spite of the candid, sometimes angry comments expressed during the conferences, no one, either professional or paraprofessional, administrator or service provider, white or Indian, was ready to quit. On the contrary, there were indications that frankness was a characteristic of the conference which, coupled with a willingness to share and learn from one another, offered promise for the future.

Those from the Indian Health Service, the mental health centers, and the state and federal bureaus recognized the problems facing tribal people living on and off the reservation. Massive unemployment, rural isolation, racial and cultural stereotype, are bound up with alcoholism, suicide, academic failure and illiteracy, family violence, child abuse and mental illness of all types. No one doubts that a massive effort on the part of all agencies will be required if there is to be progress. They recognize that it must be a sustained effort supported by personal commitment on the part of those involved. Some of the most successful programs reported during the conference were those carried out by single professionals working in small settings over long periods of time. Yet, regardless of this evidence, success in the form of effective programs had many origins and frequently surprising histories. Thus, the objective of sharing and

discovering what works, or what can be made to work, was accomplished.

Several themes recurred in the presentation of the programs. Among the most outstanding were those of professionalism, racism-culture, and conceptual orientation. To a degree, these themes are interdependent. Each affects the other in direct and indirect ways and must be considered in the development and maintenance of programs. The term professional, referring to an individual with specialized knowledge and often long academic preparation, also includes an element of "calling". Usually, a professional is one who confesses faith or affirms the value of a particular practice or set of processes.

Professionalism

In different ways, presenters considered whether outreach workers, mental health workers, or cultural specialists could deliver the in-depth treatment necessary to meet the challenges posed by schizophrenia, psychotic depression, or chronic alcoholism, i.e., serious mental and emotional disorders. Is life experience as a tribal person, as a member of the minority race with entry level professional training, enough? The answers, like many offered, were both yes and no. It depends on the task and the demands of the situation. Clearly tasks such as needs assessment, or developing a grant and managing effective program evaluation, call for the most complex and abstract of the helping professional's skills. Dr. Peter Chommie clearly recognized the place for this knowledge and skill at Standing Rock. His knowledge of assessment techniques, ability to train assistants and interpret data, are essential elements of his program's growth. On the other hand, the experience of the Navajo program, utilizing "driver-translators" skilled in putting shrink talk into common Navajo indicates a limitation of verbal treatment approaches. Indian professionals identified the highly abstract nature of the professionals' advanced training as a barrier to

effective treatment. Dr. Gerrish emphasized the link between credibility, a very human quality, and the ability to deliver services that work. Repeatedly, presenters recognized the role of in-service training and consultation as important professional tasks.

Requirements for licensure or particular degree status, established by the professionals who operate in isolated racial-cultural settings, e.g., where there are no Indian people, are complicating the establishment and maintenance of mental health services. As long as reimbursement or center accreditation depends upon the number of ACSW's or Ph.D.'s on staff, or upon the academic degree of the service provider, problems of this nature will persist. Centers can and do provide effective services using non-degreed or entry level staff, as in eastern Montana, when they can commit federal or state funds for staff salary and adequate professional support and inservice training. Yet, a financial commitment alone is insufficient to guarantee program continuity. Even Indian professionals recognized the problems of burning out. One program reported being unstaffed for over two months while another said they discovered that they were acting as a training ground for other social agencies. As their entry level professionals developed confidence and skill through inservice training, they tired of the monumental challenges they faced and moved on to other agencies in the same community.

The social cost of space, a concept familiar in the rural mental health movement, is an inescapable part of the delivery of services to Indian people on reservations. No other racial-cultural minority in this country lives in the relative isolation of the reservation. Professionals desiring to work with Indians must be prepared to face the consequences of reduced occupational, social and recreational variety. The relationship between environmental complexity and information processing has been shown to have important effects upon the behavior

of both individuals and groups (Schroder, H. M., et. al., Human Information Processing, 1967). Such qualities of rural environments as information restriction and deprivation, static unchanging situations and those which change little as a result of personal effort contribute to a lower level of information. As a consequence, individuals who receive professional preparation which was more complex may experience stress. Efforts to increase the level of information through program development or group action may fail, thus contributing to personal frustration or rejection by the community. At this time in our understanding, we have little specific knowledge of the way in which professionals, or those who have received professional training, will react to new and changing environmental and cultural situations. For those interested in the study of rural mental health or the ecology of human behavior, the issues raised by this conference offer fertile ground for research.

Cultural-Racial Issues

Racial prejudice, poverty and social isolation were identified as major experiences in the lives of Indian people. Such experiences cannot be understood vicariously but are an intrinsic element of being Indian. Philosophical or treatment approaches which fail to take this into consideration are quickly rejected. The "melting pot" of American culture is viewed as a racist effort to eliminate Indian culture. Most Indian participants, including those who had achieved the highest levels on their professional ladders, expressed frustration and bitterness for their early schooling.

Those professionals from the white race who have come up through the social classes by educational achievement often view education as a benign facilitative procedure. From the perspective of Indian people, therapists and educators may be seen as hostile or subversive. Traditionally, Indian people have viewed those

who use words with caution or outright suspicion. The relationship between words and experience in the socialization of Indian children, as discussed by Mr. Bates, establishes a linguistic basis for the motivational and behavioral differences between Indians and whites.

To view culture as a dependent variable and establish programs which teach coping skills, occupational skills or values may be shortsighted and oversimplified. That such a given as time could be conceived in any other way but as duration is alien to most empirically trained mental health professionals. Yet, for the Zuni people, time is not fixed or measurable, but a characteristic sequence of events, such as the maturation of sheep or the cycle of corn, neither of which are comparable (Hall, E. T., The Silent Language, 1973). Whorf drew the conclusion after a linguistic analysis of the Hopi language that there were no words, grammatical forms, constructions or expressions which referred to time as Westerners understood it. Nonetheless, the language was capable of describing correctly all observable phenomena (Whorf, B. L., Language, Thought and Reality, 1956). There is, then, justification for the concern expressed by both Indian and non-Indian professionals about the limitations of our present treatment approaches and their potential for alienating those they are supposed to help.

In some ways, a parallel exists between the mental health professional who wishes to develop and deliver services in reservation settings and the anthropologist studying cultures in more alien regions. Rappaport's concern for ritual and its relationship to language and thought (Rappaport, R. A., "The Sacred in Human Evolution", in Annual Review of Ecology and Systematics, 1971) led him to conclude that there was a relationship between the ultimate sacred propositions of a people and the particular social forms which characterized their tribal group. As Dr. Gerrish noted earlier, it is of utmost importance for those working with tribal people to participate, to the degree permitted by custom, in

the activities of the people. This may be the only way that certain information can be communicated. The methods of case management and providing help familiar to the professionally trained individual are based upon a system of reasoning which is rational in nature. It seems possible that the systems of thinking and reason which form the basis of Native American Indian beliefs may have a significantly different basis which will require an ability to mentally change pace on the part of those choosing to work in that world. In recognition of this possibility, some contributors saw a role for the traditional native healer in the service delivery system. Such a role would be essential if Rappaport's conclusions are correct. Those interested in pursuing the point further may wish to consider the work of Lopez ("The American Indian Mind", in Quest, September/October, 1978) who has identified the place of such concepts as health, poverty, family and time in the thought of Indian people.

Conceptual Orientation

For the most part, participants espoused no particular theoretical or conceptual framework in carrying out their work. References were made to general systems theory and learning theory; however, no effort was made to consolidate or articulate any new model for working with tribal people. The direct service providers identified qualities of character such as spontaneity, openness and flexibility as essentials in working with tribal people. The premise that all people are alike, that all people learn and can be viewed in that concept, was rejected by a number of participants.

A number of participants seemed to believe that too strict an adherance to any one conceptual orientation could be counterproductive. A flexible approach, both in the development of programs and in sustaining management practices, was called for. Mr. Lane's discussion of the potential barriers to service implied

in current management and evaluation research procedures characterized this concern on the part of both service providers and management.

Appreciation for the interdependence of service providers and tribal government, a concept associated with general systems theory, was frequently voiced by Indian Health Service and mental health staff. When Indian people in tribal government and professional roles identify common target populations and agency resources, programs develop which facilitate cooperation and minimize confrontation. When mental health centers attempt to operate independently, program development is inconsistent. Perhaps the diversity associated with tribalism in North America prevents the application of a single conceptual approach to the establishment and delivery of mental health services; on the other hand, perhaps our conceptualizing has been over limited factors; i.e., socio-economic level, family structure, occupational patterns. The inclusion of an additional dimension, belief system, or to use Rappaport's terminology - ultimate sacred propositions - could provide a better understanding of service forms and program development. Certainly the recognition of the role of the native healer points in this direction.

The conference pointed out the outstanding problems which face the mental health system in its efforts to work with Native American people. It also pointed out the readiness of Native Americans to work with and use the mental health system in the context of their life as they saw it. Increased self-determination for Indian people may require change in the forms of mental health service delivery as we presently understand it. Our standards of excellence in the level of training may be too high, not because there is anything particularly wrong with them, only that the concepts associated with them are incommensurate with the values of those who will utilize the services. Where ways can be found to work cooperatively, or where the knowledge and skills of the psychologically

trained white professional can be utilized, there is every reason to believe they will be well received. The readiness of the mental health system to respond to the needs of Indian people and the manner in which the system makes itself available will determine the extent and quality of the relationship between the mental health system and Native Americans.